MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04109

Reg. Dist. No. 105

1. PLACE OF DEATH
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waldorf md
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md — COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waldorf md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Virgie	Irene	Adams	4 -	29	1952

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W		3-13-1881	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Her Family	Rural Waldorf md	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Peter Pickeral	Rebecca King

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	No	Maggie Pickeral, Accokeek md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Congestive Heart Failure	11-4-52
443 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	
(c) Hypertensive Heart Disease	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 11-4-52, to 4-28-52, that I last saw the deceased alive on 4-28-52, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. Redden M.D.		Waldorf Md	4-30-52

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	5-1-52	Okeand	Waldorf	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5-2-52	M. L. Monroe	Hunter & Ryon	Waldorf md

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAY 5 1952
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04110

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 106

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY: Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Indian Head
LENGTH OF STAY (in this place): 62 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: None

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Indian Head Md
STREET ADDRESS (If rural, give location): None

3. NAME OF DECEASED (Type or Print): (First) Albert (Middle) (None) (Last) Jackson

4. DATE OF DEATH: (Month) (Day) (Year) 4-27-52 19

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 8-11-1888

9. AGE last birthday: 63 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Indian Head Md

12. CITIZEN OF WHAT COUNTRY?: US.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Annie Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If year, give war or dates of service): 1917

16. SOCIAL SECURITY NO.: 219-12-2846

17. INFORMANT AND ADDRESS: John Doniver, Indian Head Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Cardiac Dilatation	Immediate
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Obesity -Hypertension -Arterial	Indefinite
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-27-52, 19..., to 4-27-52, 19..., that I last saw the deceased alive on ..., 19..., and that death occurred at 8-30 AM m., from the causes and on the date stated above.
Was found dead in bed 9-30 AM 4-27-52

SIGNATURE: James E. Andrews, M.D. (Degree or title) — ADDRESS: Indian Head Md. — DATE SIGNED: 4-27-52

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 4/30/52 — NAME OF CEMETERY OR CREMATORY: St. Chas. — LOCATION (City, town, or county) (State): Glymont, Md

DATE REC'D BY LOCAL REG.: 4/28/52 — REGISTRAR'S SIGNATURE: Otey Price

24. FUNERAL DIRECTOR: Penny Mason — ADDRESS: Spring Md

RECEIVED
MAY 14 1952
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04111

CERTIFICATE OF DEATH

Reg. Dist. No. ~~24~~ 106 2

1. PLACE OF DEATH: COUNTY Charles MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pomonkey — LENGTH OF STAY (in this place) 62 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pomonkey, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Bessie Lorraine (Middle) (Last) Mack

4. DATE OF DEATH (Month) 4-4-52 (Day) 31 - [illegible] (Year) 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days	If under 24 hrs. Hours	Min.
Female	Negro		3-31-1890	62 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife	none	Charles County Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nathan Keys	Eliza Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
no		none	Doris L Green, Pomonkey Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — Immediate

331X

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterial Sclerosis — Indefinite

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
none				

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-29-52, 19....., to 4-4-52, 19....., that I last saw the deceased alive on 4-4-52, 19....., and that death occurred at 7-20 A.m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS Indian Head Md. DATE SIGNED 4-4-52

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town or county) (State)
	4-8-52	POMONKEY M.D.	Charles Co. ~~WASHINGTON D.C.~~ Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April-5-52	Edna F. Collins Odey Price	JOHN T RHINES	901-3rd. ST. SW

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-115

RECEIVED
APR 10 1952
BUREAU V. S.

04112

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH: COUNTY Charles. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Waldorf Md.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Waldorf Md.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Colton (Middle) Makle. (Last)

4. DATE OF DEATH (Month) April. (Day) 13. (Year) 1952

5. SEX M

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH April. 1st. 1877

9. AGE last birthday 75 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Self. Owner

11. BIRTHPLACE (State or foreign country) Charles Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME James Makle.

14. MOTHER'S MAIDEN NAME Matilda. ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.

16. SOCIAL SECURITY No. No.

17. INFORMANT AND ADDRESS Sophia Makle. Wife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Apoplexy

442X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardio Vas Rural Dis

(c) c̄ Aortic regurgitation —

INTERVAL BETWEEN ONSET AND DEATH: About 1 year

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/1, 1952, to 4/13, 1952, that I last saw the deceased alive on 4/10, 1952, and that death occurred at 9:30 P m., from the causes and on the date stated above.

SIGNATURE Sm. D. Weber (Degree or title) M. D. ADDRESS DATE SIGNED 4/16/52

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF April. 16. 52

NAME OF CEMETERY OR CREMATORY St. Peters.

LOCATION (City, town, or county) (State) Waldorf Md.

DATE REC'D BY LOCAL REG. 4-16-52

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Huntt And Ryon. Waldorf Md. ADDRESS

M

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 18 1952
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04113

CERTIFICATE OF DEATH

Reg. Dist. No. 101

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY: Charles; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pisgah Md.; LENGTH OF STAY (in this place): 86; HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Pisgah Md.; COUNTY: Charles; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pisgah; STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Jennie Queen (Middle) Matthews (Last)

4. DATE OF DEATH: (Month) 4- (Day) 2- (Year) 52 19

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 9-15-65

9. AGE last birthday: 86 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Charles County Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Henry Queen

14. MOTHER'S MAIDEN NAME: Sarah Francis Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Albert Matthews

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: Immediate

420.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio -Sclerpsis — Indefinite

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-27-52, 19....., to 4-1-52, 19....., that I last saw the deceased alive on 4-1-52, 19....., and that death occurred at 9-50 P.....m., from the causes and on the date stated above.

SIGNATURE: James E Andrews (Degree or title) ADDRESS: Main Street Md DATE SIGNED: 4-2-52

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 4-5-52 — NAME OF CEMETERY OR CREMATORY: St. Charles — LOCATION (City, town, or county): Glymont (State): Md.

DATE REC'D BY LOCAL REG. 4-5-52 — REGISTRAR'S SIGNATURE: Mary Smithmond

24. FUNERAL DIRECTOR: Penny + Cofer — ADDRESS: Bryans, Md

RECEIVED
APR 8 1982
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY CHARLES MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY CHARLES
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HUGHESVILLE — LENGTH OF STAY (in this place) 44 YEARS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HUGHESVILLE
HOSPITAL OR INSTITUTION OR STREET ADDRESS —	STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print)	(First) STEPHEN	(Middle) IGNATIUS	(Last) QUADE	4. DATE OF DEATH	(Month) APRIL	(Day) 28	(Year) 1952
5. SEX MALE	6. COLOR OR RACE WHITE-US	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH JUNE 11, 1871	9. AGE last birthday 80 yrs.	If under 1 year Months.	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO DEALER (RETIRED)	10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE SALES + SERVICE	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? LIFE				
13. FATHER'S NAME LLEWLLYN QUADE	14. MOTHER'S MAIDEN NAME MARY PILKERTON						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)	16. SOCIAL SECURITY NO. NONE	17. INFORMANT AND ADDRESS MR. ELMER QUADE: HUGHESVILLE, MD.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) ARTERIO SCLEROTIC HEART DISEASE (CARDIAC FAILURE)	6 WEEKS
4200 Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) GENERALIZED ARTERIO-SCLEROSIS	10 YEARS
	(c) DIABETES MELLITUS (MILD-DIET CONTROLLED)	4 YEARS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) — (COUNTY) — (STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from January, 1948, to April 28, 1952, that I last saw the deceased alive on April 28, 1952, and that death occurred at 5 40 EST A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John H. Griffin	M.D.	HUGHESVILLE, MD.	4/25/52

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 4/30/52	NAME OF CEMETERY OR CREMATORY Old Fields	LOCATION (City, town, or county) (State) Hughesville, Md.
DATE REC'D BY LOCAL REG. 4/28/52	REGISTRAR'S SIGNATURE Julia H Casey	24. FUNERAL DIRECTOR Huntt + Ryon	ADDRESS Waldorf, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A1

RECEIVED
APR 30 19[illegible]
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04115

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY CHARLES — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LA PLATA — LENGTH OF STAY (In this place) 15 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS PHYSICIANS' MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY CHARLES
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BENEDICT
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) SARAH (Middle) ELIZABETH (Last) ROACH

4. DATE OF DEATH: (Month) APRIL (Day) 9 (Year) 1952

5. SEX: FEMALE

6. COLOR OR RACE: WHITE-U.S.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: SEPTEMBER 14, 1868

9. AGE last birthday: 83 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Moran

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Moran A. Roach, Benedict, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) CORONARY THROMBOSIS, ACUTE — 1 HOUR

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) CORONARY SCLEROSIS — 2 YEARS

(c) GENERALIZED ARTERIO-SCLEROSIS — 10 YEARS

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: NONE

19b. MAJOR FINDINGS OF OPERATION: NONE

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from SEPTEMBER, 19 47, to APRIL 9, 1952, that I last saw the deceased alive on APRIL 9, 1952, and that death occurred at 8 20 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

John N. Griffin, M.D. — Hughesville Md. — 4/10/52

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 4/14/52 — NAME OF CEMETERY OR CREMATORY: St. Mary's — LOCATION (City, town, or county) (State): Bryantown, Md.

DATE REC'D BY LOCAL REG. 4/14/52 — REGISTRAR'S SIGNATURE: Julia H. Casey — 24. FUNERAL DIRECTOR — ADDRESS: Hunt & Ryon, Waldorf, Md.

RECEIVED
APR 16 1952
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 04116

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Faulkner — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Faulkner
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JAMES	LEO	WATHEN	APRIL	2	1952

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs: Hours	Min.
M.	W.		Feb. 2 1898	54 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman	State Rds. Com.	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Monroe Wathen	Chloe Hatten Herbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
yes		Mary Louise Wathen, Faulkner, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) ACUTE RIGHT LOBAR PNEUMONIA (UNTREATED)	1-2 DAYS
490 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) CORONARY ARTERIOSCLEROTIC HEART DISEASE	2 YRS
	(c) HEPATIC CIRRHOSIS	5 YRS.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	CHRONIC ALCOHOLISM	20 YRS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?		

22. *I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Farran Parker	M.D.	La Plata, Md.	4-3-52

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-5-52	St. Mary's	Newport Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4/7/52	Julia H. Casey	Hewitt & Lyon	Waldorf, Md

RECEIVED
APR 10 1952
BUREAU V. S.